LIMITATIONS AND EXCLUSIONS

We will not pay benefits for either:

1. Alcoholism or chemical dependency. However, we will pay for chemical dependency that results from drugs administered on the advice of and in such doses as prescribed by a Doctor.

2. Mental or Nervous Disorders. (A Mental or Nervous Disorder is a neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder of any kind without demonstrable organic origin. Alzheimer's disease, Parkinson's disease, and senile dementia are not Mental or Nervous Disorders under this Policy.)

PREMIUMS

PAYMENT OF PREMIUM: All premium due dates are determined from the Policy Date. The first premium was due before we delivered the Policy. All other premiums are due in advance of the period they are to cover. Premiums after the first one are to be payable to us. The premiums for this Policy may change, as stated in the Renewal Premiums provision.

REFUND OF PREPAID PREMIUMS: If we are notified of your death, we will refund any prepaid premium for any period beyond the end of the month in which your death occurred.

RENEWAL PREMIUMS: We may change the premium rates for this Policy. If we do change such premiums, we will do so only if:

1. We change the premiums for all policies which have the same form number as this Policy and which were issued in the same class and in the same state as this Policy; and

2. We have given you at least 45 days prior notice of such change.

ALTERNATE PREMIUM PAYOR: If you have given us notice of an alternate premium payor, as shown in the Application, we will send the alternate premium payor a copy of any late premium notice and a copy of any lapse notice. You may change the alternate premium payor by giving us written notice.

TERMINATION OF COVERAGE

TERMINATION FOR NONPAYMENT OF PREMIUM: Your coverage will end if the required premium is not paid when due or within the 31 day grace period. This will not affect a claim for expenses incurred before the coverage ended.

GRACE PERIOD: This Policy has a 31-day grace period. This means that if a premium is not paid on or before the date it is due, it may be paid during the following 31 days following the due date. During the grace period, this Policy will stay in force.

REINSTATEMENT: If the renewal premium is not paid before the Grace Period ends, the Policy will lapse. Our later acceptance of the premium without requiring an application for reinstatement will reinstate this Policy.

If we require an application, you will be given a conditional receipt for the premium. If the application is approved, the Policy will be reinstated as of the approval date. Lacking such approval, the Policy will be reinstated on the 30th day after the date of the conditional receipt unless we have previously written you of our disapproval.

If the Policy is reinstated, we will cover only loss that results from a confinement that begins after the date of reinstatement. In all other respects your rights and our rights will remain the same, subject to any provisions imposed by us.

Premium must be paid from the date of the last premium payment at the rate that would have been in effect had the Policy been in force. Payment must be made to us within 15 days from the date it is requested by us.

EXTENDED REINSTATEMENT: Within 120 days after the Policy lapses for nonpayment of premium, you or any person authorized to act on your behalf, may request reinstatement of the Policy if you were diagnosed as having a cognitive impairment at the time the Policy lapsed. Cognitive impairment means that a Doctor has determined you are unable to think, perceive, reason or remember.

We may request that a Doctor provide written certification that diagnosis of cognitive impairment was established at the time the Policy lapsed. Upon our receipt of such certification, the Policy will be reinstated without evidence of insurability.

The reinstated Policy will cover loss which occurred from the date the Policy lapsed. Coverage will be provided at the same level provided prior to reinstatement.

Premium must be paid from the date of the last premium payment at the rate that would have been in effect had the Policy been in force. Payment must be made to us within 15 days from the date it is requested by us.

CLAIM PROVISIONS

NOTICE OF CLAIM: Written notice of claim must be given to us within 180 days after a covered loss starts or as soon as reasonably possible. The notice must be given to us at our Home Office. Notice should include your name and Policy number.

CLAIM FORMS: When we receive your notice of claim, we will send you forms for filing proof of loss. If these forms are not sent to you within 15 days after we receive your notice, you will meet the proof of loss requirements by giving us a written statement of the nature and extent of the loss. We must receive this statement within the time limit stated in the Proof of Loss section.

PROOF OF LOSS: Written proof of loss must be furnished to us within 90 days after we receive notice of claim. We will not deny or reduce any benefit because we are not furnished proof in the time required if it is not possible for you to do so. However, proof must be furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than 18 months from the time proof is required.

TIME OF PAYMENT OF CLAIMS: Benefits payable under this Policy will be paid as soon as we receive proper written proof of loss.

PAYMENT OF CLAIMS: We will pay all benefits to you. If any accrued benefits are unpaid at your death, we may pay them to your spouse, if living, otherwise to your estate. We may pay benefits up to $1,000 to anyone related to you by blood or by connection of marriage whom we consider to be entitled to the benefits if the benefits are payable: to your estate; or to a person who is a minor or otherwise not competent to give a valid release. Any payment made by us in a good faith under this provision will fully discharge us to its extent.

CLAIM APPEAL PROCESS: Our procedure is to treat each claim submission fairly, based on the facts we are provided. You may have additional information that could change a claim decision. To provide a full and fair review, we have established an appeal process in the event you want to appeal or review a claim decision. You will be notified of your right to appeal and the appeal process at the time an initial claim decision is made.

PHYSICAL EXAMINATION: At our expense, we have the right to have you examined as often as reasonably necessary while a claim is pending.

LEGAL ACTION: No legal action may be brought to recover on this Policy within 60 days after written proof of loss has been given as required by this Policy. No action may be brought after three years from the time written proof of loss is required to be given.

GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES: This Policy, including the Application and any attachments and Riders, is the entire contract between you and us. No change in this Policy will be valid until approved, in writing, by an officer of the Company and the approval has been forwarded to you for attachment to your Policy. No other person has the authority to change this Policy or to waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: After six months from the Policy Date, no misstatements, except fraudulent misstatements, made in the Application may be used to void the Policy or to deny a claim for loss incurred after the expiration of the six-month period.

MISSTATEMENT OF AGE: If your age has been misstated, we will pay only such amount as the premium paid would have purchased at the correct age.

ASSIGNMENT: Any assignment of your interest under this Policy must be in writing. It must be filed in our Home Office, prior to payment of any benefit. We assume no responsibility for the validity of any assignment.

FREE CHOICE OF A DOCTOR: You have free choice of a Doctor.

CONFORMITY WITH STATE STATUTES: Any provision of this Policy which, on its effective date, is in conflict with the laws of the state in which you live on that date is amended to conform to the minimum requirements of such laws.

TRANSPORT LIFE INSURANCE COMPANY
714 Main Street, Fort Worth, Texas 76102

ALTERNATE PLAN OF CARE RIDER

NOTICE. This Rider is made a part of the Policy to which it is attached. It is effective on the Policy Date shown in the Schedule. This Rider is subject to all of the Policy definitions, provisions, exceptions and limitations which are not inconsistent with the provisions of this Rider.

If you would otherwise require confinement in a Nursing Home, we may pay for the cost of services under a written Alternate Plan of Care, if appropriate alternative care is a medically acceptable option.

The Alternate Plan of Care:

1. Must be agreed to by you, your Doctor, and us;
2. May be initiated by you or us;
3. Will be developed by or with health care professionals.

Suggested services, benefit levels and location of services will be specified in the Alternate Plan of Care. They may be different from or not otherwise covered by the Policy. Your agreement to participate in an Alternate Plan of Care will not waive any of your or our rights under the Policy. Any plan adopted, including the benefit levels to be payable, must be mutually agreeable to you, your Doctor, and us.

The total of all benefits paid under the Policy and this Rider will not be more than the Long Term Care Benefit Amount multiplied by the Maximum Days.

Some examples of services that may be provided in an Alternate Plan of Care are:

1. Building a ramp for wheelchair access; or
2. Modifying a kitchen or bathroom; or
3. Care provided in Alzheimer's Centers or similar arrangements.

This Rider is effective on the Policy Date.

TRANSPORT LIFE INSURANCE COMPANY

Elisabeth S. DeLargy
Secretary

Gaetano La Fauci Jr.
President

TRANSPORT LIFE INSURANCE COMPANY

714 Main Street
Fort Worth, Texas 76102

Should any dispute arise, please write to the Company. The Department of Insurance should be contacted only after the complainant and the Company or its agent have failed to produce a satisfactory solution to a problem. The Department of Insurance may be reached at the following address and telephone number: Department of Insurance, Consumer Services Division, 300 South Spring Street, Los Angeles, California 90013, (800) 927-4357.

CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT NOTICE CONCERNING GENERAL PURPOSES AND COVERAGE LIMITATIONS

Residents of California who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the California Life and Health Insurance Guaranty Association. The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however, as noted in the box below.

The California Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in California. You should not rely on coverage by the California Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is *NOT* provided for your policy or any portion of it that is not guaranteed by the insurer which is excluded from coverage, or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. *However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.*

Policyholders with additional questions may contact:

The California Life and Health Insurance Guaranty Association
P.O. Box 70069
Los Angeles, CA 90070

California Department of Insurance
100 Van Ness Avenue - 17th Floor
San Francisco, California 94102

The state law that provides for this safety-net coverage is called the California Life and Health Insurance Guaranty Association Act. On the back of this page is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Association.

(please turn to back of page)

COVERAGE

Generally, individuals will be protected by the California Life and Health Insurance Guaranty Association if they live in this state and hold a life insurance contract, an annuity, or health insurance contract, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy was issued by a charitable organization , a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, a non-profit hospital service plan, a health care service plan, or a grants and annuities society holding a certificate of authority under Section 11520.

The Association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- unallocated annuity contracts;
- any plan or program of an employer or association that provides life, annuity, or health benefits to its employees or members to the extent the plan is self-funded or uninsured.

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the Association is obligated to pay out: The Association is not liable to pay in excess of the lesser of (1) the contractual obligations for which the insurer is liable or for which the insurer would have been liable if it were not an impaired or insolvent insurer, or (2) $200,000 in health insurance benefits, increased or decreased annually based upon changes in the health care cost component of the consumer price index. The Association cannot pay more than 80% of what the insurance company would owe under a policy or contract. Also, for any one insured life, the Association will pay a maximum of $250,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $250,000 limit, the Association will not pay more than $100,000 in cash surrender values, $100,000 in present value of annuities, or $250,000 in life insurance death benefits - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages.

PREMIUM SURCHARGE

Member insurers are required to recoup assessments paid to the Association by way of a surcharge on premiums charged for insurance policies to which the Act applies.

TRANSPORT LIFE INSURANCE COMPANY
714 MAIN STREET
FORT WORTH, TEXAS 76102

TRANSPORT LIFE INSURANCE COMPANY
714 Main Street, Fort Worth, Texas 76102

HOME HEALTH CARE RIDER

NOTICE. This Rider is made a part of the Policy to which it is attached. It is effective on the Policy Date or on the Rider Date shown below, whichever is later. This benefit is provided in consideration of the payment of the premium for this Rider. This Rider is subject to all of the Policy definitions, provisions, exceptions and limitations which are not inconsistent with the provisions of this Rider.

DEFINITIONS

ADULT DAY CARE CENTER: A facility which:

1. Is licensed or certified by the state as an adult day care facility; or
2. If licensing is not available in the state in which the facility is located, the facility must:

   (a) Provide or be able to arrange for nursing care under the supervision of an R.N.; provide planned therapeutic, social, and educational activities; maintain written records of services provided to each patient; and have a full-time administrator; and

   (b) Provide or arrange to provide:

      1. Necessary assistance in:

         Bathing (washing yourself, including a sponge bath, with or without extra equipment);

         Dressing (putting on and taking off clothing);

         Feeding (Consuming food that has already been prepared and made available with or without the use of adaptive utensils. 'Feeding' does not mean to prepare and cook food);

         Toileting (doing both of the following: getting on and off the toilet; and maintaining a reasonable level of personal hygiene);

         Transferring (moving from a bed to a wheelchair or other type of conveyance or furniture, and returning to the bed, as needed);

      2. Physical and restorative therapy; and
      3. Nutritional services and counseling.
      4. Constant supervision because a Doctor has determined you have a cognitive impairment which results in such a need. Cognitive impairment means you are unable to think, perceive, reason or remember. Your inability may be because of Alzheimer's disease, Parkinson's disease, or senile dementia.

HOME HEALTH CARE AGENCY: An agency or organization: which is appropriately licensed (if such licensing is required in the state where such agency operates) or is state or federally certified to provide home health care supervised by a Doctor or a registered nurse; and which maintains a complete medical record of each patient.

BENEFITS

The Waiting Period, Maximum Days and Benefit Rebuilder of the Policy apply to this Rider. You may meet the Waiting Period by receiving days of care which would qualify as:

1. Home health care;
2. Adult day care;
3. Homemaker services;
4. Confinement to a Nursing Home or a Hospice; or
5. Any combination of the above.

We will not pay benefits under this Rider for any days of care which, added to the days paid under the Policy, are more than the Maximum Days.

HOME HEALTH CARE BENEFIT: We will pay 80% of the actual charges, but not to exceed the Home Health Care Daily Benefit amount. This means that our payment may be less than the actual charge because our payment will not exceed an amount equal to the Home Health Care Daily Benefit amount shown in the Schedule for the following services:

1. Assistance with:
   a. Bathing (washing yourself, including a sponge bath, with or without extra equipment);
   b. Dressing (putting on and taking off clothing);
   c. Feeding (Consuming food that has already been prepared and made available with or without the use of adaptive utensils. 'Feeding' does not mean to prepare and cook food);
   d. Toileting (doing both of the following: getting on and off the toilet; and maintaining a reasonable level of personal hygiene);
   e. Transferring (moving from a bed to a wheelchair or other type of conveyance or furniture, and returning to the bed, as needed); or

   Assistance may be provided by a health worker on the staff of a Home Health Care Agency (other than a Doctor, nurse or professional therapist);
2. Occupational, respiratory, physical and speech therapy;
3. Nursing care services requiring the skills of a graduate registered nurse (R.N.); or
4. Constant supervision because a Doctor has determined you have a cognitive impairment which results in such a need. Cognitive impairment means you are unable to think, perceive, reason or remember. Your inability may be because of Alzheimer's disease, Parkinson's disease, or senile dementia.

Services must be prescribed by a Doctor and performed by a Home Health Care Agency.

We will not pay for services provided by a member of your Family. We will not pay for any other services including shopping, housekeeping or transportation.

hese services must be:

1. Medically necessary (care that is appropriate to the diagnosis, widely accepted by the practicing peer group based upon scientific criteria, and not experimental or investigative); or
2. Because you are unable to perform two or more of the following activities:
   a. Bathing (washing yourself, including a sponge bath, with or without extra equipment);
   b. Dressing (putting on and taking off clothing);
   c. Feeding (Consuming food that has already been prepared and made available with or without the use of adaptive utensils. 'Feeding' does not mean to prepare and cook food);
   d. Toileting (doing both of the following: getting on and off the toilet; and maintaining a reasonable level of personal hygiene);
   e. Transferring (moving from a bed to a wheelchair or other type of conveyance or furniture, and returning to the bed, as needed); or
3. Because a Doctor has determined you have a cognitive impairment resulting in a need for constant supervision. Cognitive impairment means you are unable to think, perceive, reason or remember. Your inability may be because of Alzheimer's disease, Parkinson's disease, or senile dementia.

You may receive these services in your residence, another private home, a home for the retired or aged, or a place providing residential care.

HOMEMAKER BENEFIT: Subject to the limits stated below, we will pay 80% of the actual charges, but not to exceed the Homemaker Daily Benefit amount. This means that our payment may be less than the actual charge because our payment will not exceed an amount equal to the Homemaker Daily Benefit amount shown in the Schedule for the following services:

1. Shopping;
2. Housekeeping;
3. Transportation;
4. Laundry; or
5. Cooking.

We will pay this benefit for one day of services in a week in which you have three days of care for which the Home Health Care Benefit is payable. A week is seven consecutive days and begins at 12:01 a.m. Sunday and ends at midnight, the following Saturday.

Services must be provided by a Home Health Care Agency in your home, another private home, a home for the retired or aged or a place which provides residential care. We will not pay for services provided by your Family.

ADULT DAY CARE BENEFIT: We will pay 80% of the actual charges, but not to exceed the Adult Day Care Daily Benefit amount. This means that our payment may be less than the actual charge because our payment will not exceed an amount equal to the Adult Day Care Daily

Benefit amount shown in the Schedule for any of the following services in an Adult D y Care Center:

1. Nursing care;
2. Therapeutic, social and educational activities;
3. Assistance with:
   a. Bathing (washing yourself, including a sponge bath, with or without extra equipment);
   b. Dressing (putting on and taking off clothing);
   c. Feeding (Consuming food that has already been prepared and made available with or without the use of adaptive utensils. 'Feeding' does not mean to prepare and cook food);
   d. Toileting (doing both of the following: getting on and off the toilet; and maintaining a reasonable level of personal hygiene);
   e. Transferring (moving from a bed to a wheelchair or other type of conveyance or furniture, and returning to the bed, as needed);
4. Physical and restorative services;
5. Nutritional services and counseling; or
6. Constant supervision because a Doctor has determined you have a cognitive impairment which results in such a need. Cognitive impairment means you are unable to think, perceive, reason or remember. Your inability may be because of Alzheimer's disease, Parkinson's disease, or senile dementia.

We will not pay for services provided by your Family or for care as a resident bedpatient or 24-hour care.

RESPITE CARE BENEFIT: We will pay 80% of the actual charges, but not to exceed the Respite Care Daily Benefit amount. This means that our payment may be less than the actual charge because our payment will not exceed an amount equal to the Respite Care Daily Benefit amount shown in the Schedule for each day of respite care. Respite care is care provided through a Home Health Care Agency, including companion or live-in care, to temporarily relieve an unpaid person who is providing you with care in your home or another private residence.

We will pay for fourteen days of respite care each Rider Year. A Rider Year begins on the Rider Date and ends on the anniversary of the Rider Date. Unused days cannot be carried over into the next Rider Year. A day of respite care is limited to a 24-hour consecutive period during which you receive respite care. Respite care which extends beyond the 24-hour period will be considered another day.

We will not pay for services provided by your Family. You do not have to meet the Waiting Period. This benefit does not count toward the Maximum Days and is not eligible for the Benefit Rebuilder.

Rider Date, if different from the Policy Date:_____

TRANSPORT LIFE INSURANCE COMPANY

Elisabetta S. DeLargy

Secretary

Gaetano M. Lasalandra

President